
THE USE OF INTUITION BY INTRAPARTAL NURSES

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ABSTRACT

Fifteen intrapartal nurses participated in this qualitative, descriptive study of the use of intuition in caring for laboring clients. Demographic information, including participant self-rating of intuitive ability on a visual analog scale, was obtained. Personal interviews with a predetermined interview schedule were audio-taped. Definitions of intuition and how nurses use intuition in their clinical practice, including supports and barriers to its use were explored. Examples of the use of intuition by intrapartal nurses are given. One recommendation for further study is the development of instruments to empirically measure intuitive ability. Enhancement of patient care through acceptance of intuitive judgment was an implication for nursing practice. The study findings confirmed the use of intuition by intrapartal nurses as an integral part of their clinical nursing practice.

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CHAPTER ONE

INTRODUCTION

Overview of Problem

Thirty years ago, Mc Cain wrote Nursing by Assessment-Not Intuition, and stated that "nursing, as it is taught and practiced today, is primarily intuitive nursing has not developed a precise method of determining when nursing intervention is needed", (1965, p. 82). Mc Cain argued that to practice effectively, a nurse must assess the patient to determine the nursing needs of each individual client. She states that "nurses must, with the majority of patients, reach a point where their plans for care are not based on hunch alone", (1965, p. 84). While that position was important in the development of nursing science, it fails to explain the experience of practicing nurses who report the use of methods other than linear analysis in decision making.

In the past decade nurses have begun to describe the critical part intuition plays in clinical practice. Benner's work on skill acquisition (1982, 1983, 1984, 1987) described how the expert nurse acknowledges the role that intuition plays in decision making. Benner stresses that nurses must have confidence in their intuition as part of that decision-making process.

To date, the study of intuition in nursing has hardly been exhaustive. There is increasing evidence that nurses, depending upon their level of experience, use intuition in their clinical practice to make decisions in patient care (Benner & Tanner, 1987; Gerrity, 1987; Pyles & Stern, 1983; Rew, 1988a, 1988b, 1991b; Schraeder & Fischer, 1987; Young, 1987). While the basic

education of nurses focuses on a linear model of nursing practice, evidence is mounting that nursing experts rely on much more than a simple analytic reasoning algorithm in making decisions about patient care. Schraeder and Fischer (1986, 1987) argue convincingly that nurse researchers should direct their attention to studying the phenomenon of intuition as the art of nursing may indeed take place on an intuitive level. To provide a greater understanding of how nursing is actually practiced, researchers must describe and document the evolvment and influence of this mode of thinking and how it is influenced by the environment.

There is limited research in nursing that addresses the use of intuition and the implications of intuition use in clinical nursing practice. Earlier studies have identified the use of intuition in critical care, home health care, psychiatric-mental health, and neonatal intensive care (Benner & Tanner 1987, Pyles & Stern 1983, Rew 1988, 1990, 1991b, Ruth-Sahd 1993, Schraeder & Fischer 1987, Young 1987). Questions regarding the use of intuition in the clinical practice of intrapartal nurses remains unanswered.

Purpose of Study

The purpose of this study was to identify and describe the use of intuition by intrapartal nurses who care for laboring clients. The nurses perceptions of supports and barriers to the use of intuition in the intrapartal setting was explored as well.

Research Questions

The research questions to be investigated in this study are: How do intrapartal nurses caring for laboring clients define and describe intuition in

clinical practice? In what type of clinical situations do intrapartal nurses describe the use of intuition? What do intrapartal nurses identify as supports for acting on intuition in clinical practice? What do intrapartal nurses identify as barriers to acting on intuition in clinical practice?

Definition of Terms

For the purpose of this study, the following definitions apply:

- Intuition Intuition refers to the immediate knowledge of a fact or truth independent of linear thought process (Rew, 1986).
- Intrapartal nurse Licensed professional nurse with clinical experience in obstetrics currently caring for laboring clients.
- Linear thought process Process in which ideas/assessments are made one step at a time with each step leading to the next in logical progression.

Overview of Conceptual Basis

The conceptual basis of this study is Rew's descriptive work (1986, 1988a, 1988b) concerning the phenomenon of nurses' use of intuition in clinical practice. Rew (1988a) explored the works of Westcott (1968) in tracing the historical evolution of the concept of intuition, Assagioli (1965) who proposed intuition as a high level of cognition, and Bastick (1982) who clarified the concept of intuition as a phenomenon of human thought.

Westcott (1968) defines intuition as a process of reaching accurate conclusions based on inadequate information. He stresses that the relationship between intuitive abilities and the intuitive type as measured by the Myers-Briggs-Type Indicator cannot be directly correlated, but by combining and

correlating the responses of sensation and intuition we can hypothesize our intuitive problem solving performances. These two functions, responsiveness to details and the ability to extrapolate the implications of details, are required to succeed in problem solving intuitively.

In the theory of the holistic nature of the human psyche, Assagioli (1965) identifies intuition as a higher form of vision. He separates the cognitive ability of intuition from common impressions or hunches. He associates qualities of creativity and synthesis with intuition. Bastick (1982) produced a formal theory of intuitive thought processes and refers to intuition as a universal phenomenon of human thought. He proposes that there is a contrast between intuition and analytical thought, and that anxiety and competition decrease one's ability to access intuitive skills.

Rew (1986) identified the defining attributes of intuition and the antecedents as well as the consequences. She also identified empirical referents that demonstrated how the concept is determined to exist in the real world. Rew stressed the existence of empirical evidence of intuition as a personality trait and as a cognitive skill and that the concept of intuition may be measured or determined in both cognitive and affective states.

The conceptual basis for this study, Rew's descriptive work (1986, 1988a, 1988b), was chosen as it presents an analysis of the use of intuition by nurse's in clinical practice. It has been applied to nurses practicing in critical care, home health care, and psychiatric-mental health. It provides a foundation upon which to build future research regarding the importance and implications of nurses using intuition in their daily clinical practice.

Overview of Literature Review

Intuition has come to the fore in the past decade as nurses are trying to describe the important part it plays in clinical practice. Intuition was defined by Rew as "knowledge that was received in an immediate way, perceived as a whole, and not arrived at through a conscious linear, analytic process" (1991, p. 110). When discussing the need for nursing to synthesize intuitive and linear analytic knowledge, Gerrity (1987) defined intuition as a type of perception. Comprehension without reason was the definition of intuition given by Benner and Tanner (1987). According to these authors, intuition is not a mystical or accidental human capacity but a grasp of the situation that involves seeing the whole picture and recognizing patterns inherent in it from previous experiences. Further review of the literature will examine various definitions of intuition, supports and barriers to its use, and the slow acceptance of the use of intuition in the clinical practice of nursing today. Examples of studies which have identified the clinical use of intuition will be included.

Significance of Study for Advanced Nursing Practice

Identification of the use of intuition by intrapartal nurses will add to the body of knowledge regarding intuition use among nurses. The results of this study will likely demonstrate that nurses use more than simple analytic reasoning in making decisions about patient care. It may support Benner's (1987) contention that intuitive knowledge and analytic reasoning can and often do work together. Finally, the results of this investigation may help in making intuitive judgment an acceptable aspect of nursing process.

CHAPTER TWO

REVIEW OF LITERATURE

Conceptual Basis

The conceptual basis of this study is Rew's descriptive work (1986, 1988a, 1988b) concerning the phenomenon of nurses' use of intuition in clinical practice. Rew and Barrow (1987) analyzed nursing literature and concluded that the nursing discipline has largely neglected the concept of intuition. They stressed that even though the concept has been neglected it is a characteristic of nursing knowledge.

Wescott (1968) states that the philosophical and psychological background and research findings show evidence that there is a complex psychological function or functions which can be properly called intuition. This function can be explained in terms of psychological concepts and findings which are highly regarded in psychological theory.

Stating that intuition does not work as the analytical mind does from the part to the whole, Assagioli (1965) stressed that intuition perceives situations in totality. As a normal function of the human psyche, intuition is activated chiefly by eliminating those obstacles which prevent its activity. Intuition is one of the least recognized and least appreciated functions and therefore is one of the repressed functions. Non-recognition, devaluation, neglect and lack of intuition's connection with other psychological functions cause it to be repressed. A true cognitive process communicates not only the function of intuition, but its logical perception and inclusion in the existing body of knowledge. He states that the essential distinction between cognition by way

of intuition and cognition by the way of the thinking or feeling functions is that intuition is immediate, direct, and holistic.

Rew (1986) identified the defining attributes of intuition as a whole knowledge of a fact or truth; possessing immediate knowledge; and knowledge obtained without use of the linear reasoning process. Three additional attributes in intuitive experiences were identified (Rew, 1988) - inner knowing, sensing/feeling/ perceiving, and strength of feeling that affects perception. She reported that nurses experienced intuition during their clinical practice in terms of knowing how something should be done, that further action should be taken and what that action should be.

Antecedents of intuition, situations or conditions that occur prior to the concept, are given as truths or knowledge that are not apparent or available through conscious reasoning. Consequences of intuition, situations or conditions that occur as a result of the concept, verify the fact or truth through linear analysis and application of the knowledge in both theoretical and practical ways.

In a qualitative study, Rew (1988) found that nurses described three types of intuition that had been identified by Loye in 1983. These three types are: cognitive inference which occurs with spontaneous conclusions; Gestalt intuition which is the detection of missing data or hidden relationships within the total situation; and precognitive which is the ability of gaining information about the future directly rather than by inference based on past and present knowledge.

Rew's (1986) conceptual basis was chosen by this researcher as it explores the phenomenon of intuition as it pertains to nursing. It examines intuition as a phenomenon common to all humans detailing the uses of intuition, defining attributes, antecedents and consequences, and empirical referents. Intuition and its application in nursing, both in nursing education and clinical practice, is noted.

Review of Pertinent Literature

This literature review of the nursing literature regarding the use of intuition in clinical nursing practice will provide definitions, synonyms and meanings given by various researchers. The characteristics of intuitive nurses as explored in current literature will be examined. Examples of studies which identify the use of intuition by nurses in clinical practice as well as supports and barriers to its use will be explored.

Traditionally nurses have considered intuition to be irrational or accidental. Only recently have nurses started to recognize intuition as an approach to clinical judgments. According to Davidhizar (1991) intuition is much more than a hunch, a guess, an instinct, or a gut feeling. At times it appears to be a perception outside of traditional channels of sight, smell, taste, touch, or hearing. At other times, intuition appears to be a process of arriving at knowledge without conscious awareness of rational thinking. Intuition is the ability to arrange and blend diverse and complex information into a unified whole. Intuition is shown as a powerful nursing tool whether it increases the nurse's awareness of physiologic signs and symptoms or psychologic distress. It assists in the processing of information which allows the nurse to reach

logical conclusions. Intuition involves the ability to adapt skill and knowledge to individual situations and to take appropriate action. The results for nursing are accurate diagnosis, close monitoring, and improved patient care.

Definitions

In order to understand and clarify the concept of intuition, the following definitions and uses of intuition were found in dictionaries and thesaurus:

1. (knowledge obtained from) an ability to understand or know something immediately without needing to think about it, learn it or discover it by using reason (Cambridge, 1995).
2. quick and ready insight; immediate apprehension or cognition; knowledge or conviction gained by intuition; the power or faculty of attaining to direct knowledge or cognition without evident rational thought and inference (Merriam-Webster's Collegiate Dictionary, 1994).
3. the act or faculty of knowing without the use of rational processes: immediate cognition; knowledge acquired by the use of this faculty; acute insight (Webster's II, 1984).
4. immediate apprehension or cognition (Merriam-Webster's Collegiate Thesaurus, 1988).
5. stresses quick knowledge or comprehension without evidence of orderly reason, thought, or cogitation (Merriam-Webster dictionary of synonyms and antonyms, 1992).

Synonyms given for intuition are:

1. understanding, reason, intellect, soul, insight, acumen (Webster's new dictionary of synonyms, 1984).
2. intuitiveness, sixth sense; direct apprehension, unmediated perception, subconscious perception, immediate cognition, knowledge without thought or reason; insight; instinct; hunch, premonition, impression, feeling (Roget's international thesaurus, 1977).
3. anschauung, insight, intuitiveness, second sight, sixth sense (Merriam-Webster's collegiate thesaurus, 1988).
4. discernment, perception; apprehension, comprehension, understanding, grasp, mental hold; insight, instinct, prompting, sixth sense; foreknowledge, precognition, presentiment; intimation, hint, clue, hunch (Rodale, 1978).
5. reason, understanding (Merriam-Webster dictionary of synonyms and antonyms, 1992).

The definitions and uses of intuitions found in dictionaries and thesaurus concur that intuition is knowing something immediately without the step-by-step process found in rational thought. Synonyms given are sixth sense, instinct, perception, and hunch. These definitions and synonyms are the same as those given by researchers.

Agor (1984) defines intuition as seeing the big picture, sensing possibilities and implications of a particular situation or potential decision; being able to come up with a workable solution to a problem even when all the

facts for making that decision either missing or unavailable. He suggests that nurses should be tested for both inherent intuitive ability and actual use of the skill in making decisions. It is felt that this helps people not only learn about their intuitive ability but also assists them in the use of this skill.

According to Parse (1988) the intuitive-rational process can be viewed as a paradoxical phenomenon rooted in human thinking. It is a process that is used with varying levels of desire and degrees of skill to investigate phenomena. The real contribution of intuition as a way of knowing has been downplayed, considered soft and not valuable for rigorous study. Parse stressed that the major task of the researcher is to integrate into the mainstream of science a value for intuition which encompasses personal feelings as well as descriptive accounts of the event.

Tacit information, defined as information that is acquired by experience, when the experienced professional "just knows", is not given in texts according to Carroll (1988) but is known by the experts in the discipline. However, since experts are usually unaware of their knowledge, they cannot easily describe it. Certain features of a person's cognitive make-up have been identified as determining the effectiveness of the use of tacit information in the decision making process: the person's knowledge base, the person's ability to organize information, the person's ability to process information, and the person's ability to transfer information.

Burnard (1989) reiterates Jung's theories that the mind has at least four functions: thinking, feeling, sensing and intuiting. Intuition is knowledge beyond the senses. It is a "sixth sense". Knowing via our intuitive ability is

stronger than suggestion or belief. Burnard believes that nurses rely on an intuitive sense which includes taking a second look at a patient, knowing just the right question to ask patients and families, and talking with colleagues and friends. Intuition forms an important aspect of who we are and what we do.

Agan (1987) studied seven self-described holistic nurses and their perceptions of holistic nursing. A key theme that emerged from this inquiry was a feeling or sensing level of knowing which the researcher described as intuitive, psychic, subconscious, or instinctual. He states that this way of knowing resonates with emerging theory in nursing and fits with the pattern of personal knowing in nursing identified by Carper (1978). The theme of knowing in an intuitive and sensing way relates to both interpersonal and universal/interpersonal connection. This way of knowing was referred to in a variety of ways by the seven holistic nurses as they talked of their own nursing practice.

Personal knowing is described by Moch (1990) as gaining knowledge of one's self and others through introspection, integration of thoughts, and association with what is presently known. She states that personal knowing is essential to nursing and critical to professionals who focus on interpersonal processes while mixing both artistic and scientific components within their actual practice. Moch identified the components of personal knowing as: experiential knowing or becoming aware through participation and being in the world; interpersonal knowing as increased awareness through intense interaction or being-with the other; and intuitive knowing or immediately knowing something without use of reason. A "hunch" or a "feeling about

something" is often used to describe intuitive knowing. Moch states that intuitive knowing requires the personal participation of the person and may happen if the person is open and trustful that "knowing" without "knowing how" can occur.

This investigator defines intuition as a way of knowing something immediately without having available confirming clinical data. It happens spontaneously without urging. It often manifests in the nurse as a sensing or gut feeling that something is going to happen and compels the nurse to act.

Characteristics

Intuition (Young, 1987) is a method by which data are processed. Characteristics of nurses who employ this method have an open attitude toward people, are accepting of nontraditional treatment approaches, and are willing to identify their intuitive experiences. Rew (1986) concluded that often a nurse is urged to do something more for a patient based on the strength of intuition and this often leads to communication problems with physicians. The development of communication systems without the fear of reprisal is needed. Benner and Tanner (1987) identified that the expert has an intuitive grasp of the situation that involves seeing the whole picture and in recognizing patterns inherent in previous experiences.

The intuitive type as described by Gillan (1993) is the nurse who makes patients comfortable, can always say the right thing and can perceive patient's needs. These nurses understand that health care is not just about helping people to get better but also about the quality of the illness experience. She

also stresses that these nurses are not rewarded because their skills are not recognized.

Intuitive nurses take risks, based partly on intuition and tacit knowledge. They are able to do away with the ritual tasks and care for the whole patient. They have confidence to make decisions, to listen thoroughly and to know what is important to the patient. Gillan (1993) states intuitive nurses base their interpersonal relations with patients on their experience and perceptual skills, which are so important in real-life thinking and doing. Intuitive nurses can be care-plan-oriented and technologically competent but still strive to give the highest priority to the very heart of nursing which is inter-personal interactions. As their work is not prescriptive or easily documented, not easy to predict and so not easy to measure or quantify, it is hard for management to understand and value.

Examples

Pyles and Stern (1983) developed a theory of Nursing Gestalt after interviewing and observing 28 critical care nurses to explore how they determined whether a patient was developing cardiogenic shock. This was an exploratory study in which qualitative methodology was used. Data were collected from interactions and in-depth interviews with the 28 subjects. The first author conducted all interviews. The second author participated in the coding and analysis of data and directed the writing of the research report, all of which was done using grounded theory. An inter-rater reliability between the two authors is not given. These authors found that experienced critical care nurses exhibit a number of behaviors that contribute not only to the healing

process of their patients but to the development and socialization of novice nurses. Those behaviors, termed nursing gestalt, present a synergy of logic and intuition involving both conceptual and sensory acts. Using this method nurses combine basic scientific knowledge, past experience, cues from patients and the nurses' own sensations or feelings. This combination forms a gestalt of nursing data upon which critically important decisions are based.

Benner and Tanner (1987) studied 21 nurses who had at least five years of nursing experience in one clinical setting and who were identified as experts in the same clinical area by their peers. They interviewed each nurse three or more times and observed the nurses in practice at least once to determine how they used intuition in making expert clinical judgments. The interviews contained detailed narrative accounts of situations in which these nurses made a difference in patients' outcomes. Each interview included examples of Dreyfus's (1984) six key aspects of intuitive judgement: pattern recognition, similarity recognition, common sense understanding, skilled know-how, sense of salience, and deliberative rationality.

Interviews and observations of these nurses provided rich examples of intuitive judgement in clinical decision making. Benner and Tanner concluded that aspects of intuition were used by expert nurse clinicians when making clinical decisions that made life-saving differences to patients. They also noted that until recently the study of clinical judgment in nursing has been derived from two predominant perspectives: decision theory and information-processing theory. Each of these theories makes the assumption that clinical judgement is a rational calculation. Contrary to their assumptions, expert

nurses who were studied in actual practice situations approached problems with perceptions of the situations as wholes rather than as combinations of elements, bits and cues. This observation led these researchers to further explore the use of intuitive judgments by nurses in their clinical practice.

Young (1987) used the grounded theory approach in which 41 female subjects were observed or interviewed or both in a field study. All except two subjects were registered nurses in seven different agencies and a variety of clinical areas. The subjects were asked to describe their past intuitive experience. A total of 75 descriptive incidents were collected. Inductive and deductive analyses were done. The data were coded which became the practical extent of clinical intuition. Young concluded from the field data that content is intuited, whether the source of information was in the form of specific or general cues. Intuition is a method by which data are processed. Characteristics of nurses who employ this method have an open attitude toward people, were accepting of nontraditional treatment approaches, and were able to identify their intuitive experiences. Young states that if we want to expand nursing knowledge, we must make intuitive-subjective data an acceptable part of nursing process. Young stresses that intuition is a part of nursing practice and process and should not be ignored.

Schrader and Fischer (1987) interviewed fifteen nurses working in a level 3, neonatal intensive care unit. Qualitative methods were used to gather and analyze data. Over the course of one year, information was obtained from ethnographic interviews, participant observation and examination of primary documents. Tape recordings from the interviews and researcher field notes

were analyzed for emergent themes. The investigators found that the nurses who were most likely to trust and act on their intuitions were those with the most experience and technical proficiency in the neonatal intensive care units. These nurses had a strong belief in themselves and were willing to take risks. Like nurses in previous studies, they were frustrated in their efforts to communicate their intuitive experiences to others. The authors note that the phenomenon of intuitive perception has validity.

In a qualitative study of fifty-six nurses working in home health settings and critical care units, Rew (1988a) found that nurses described three types of intuition that had been identified by Loye in 1983. These three types are: cognitive inference which means being aware of something without knowing the reason; Gestalt intuition or having a deep, strong feeling which provides answers; and precognition which means the ability to predict an incident before it happens. Rew recruited a non-probability sample from two critical care units and one home health agency. A demographic information sheet and interview schedule were developed to obtain descriptive data about the subjects' experiences of intuition in clinical practice. The interview schedule contained questions concerning the subject's definitions and examples of intuition as well as descriptions of how they experienced intuition in the steps of the nursing process. The subjects were also asked what they did immediately after an intuitive experience. The interviews were conducted by Rew and three trained research assistants who tape recorded, transcribed and analyzed responses.

Nurses described three types of responses: affective, cognitive, and behavioral. Rew concluded that nurses often performed additional tasks for a

patient based on the strength of their intuition and often this caused communication problems with physicians. She noted that evidence is accumulating that intuition is a valuable component of decision making in nursing and urges nurses to support each other in finding ways to validate and communicate each type of intuitive experience in clinical nursing practice.

Sixteen nurses in psychiatric-mental health settings were studied by Rew (1991b) to determine their definitions and uses of intuition in their clinical practices. A descriptive design using content analysis was employed to answer four research questions: (a) How do psychiatric-mental health nurses define intuition in clinical practice? (b) What type of clinical situations do psychiatric-mental health nurses describe as examples of using intuition in clinical practice? (c) What do psychiatric-mental health nurses identify as supports for acting on intuition in clinical practice? (d) What do psychiatric-mental health nurses identify as barriers to acting on intuition in clinical practice? A random sample of twenty nurses was selected from a list of potential subjects who had previous or current clinical experience with child or adolescent psychiatric-mental health patients and who volunteered to be interviewed for the study. A total of sixteen nurses comprised the final sample. A personal tape-recorded interview was conducted with each subject. Content validity of the interview guide was determined on the basis that it contained similar content and format of interview guides used in previous studies of intuition in nursing by Rew in 1988 and 1990. The interviews were transcribed and analyzed for both manifest and latent content. Definitions provided by the nurses in this sample were consistent with those provided in previous studies.

The results of this study provide further evidence that nurses in clinical practice are aware of intuition in making decisions and taking actions. These similarities imply that the phenomenon of intuitive knowing is not limited to one or two clinical settings.

Supports and Barriers to the Use of Intuition

The literature contains evidence of supports and barriers to the use of intuitive judgements that nurses have reported in practice. Supports are factors, such as peer respect and trust, that encourage the use of intuition in clinical practice. Barriers are factors that discourage the acknowledgment of the use of intuition in clinical practice.

Nurses have stated that respect and trust from others, nursing peers and physicians, served as a primary support and reinforcements for including intuition in their clinical practice (Benner & Wreubel, 1982; Bourn, 1993; Gearhart & Young, 1990; Pyles & Stern, 1983; Rew, 1990; Rew, 1991; Ruth-Sahad, 1993; Schraeder & Fischer, 1986, 1987). Other means of support are sharing experiences with others and listening and receiving feed-back. Self-confidence, being receptive to your own intuition, having successful outcomes and documentation of experiences are included as examples of support to the use of intuition. Experience, maturity and a willingness to take risks are also given. Some feel that focusing on and listening to the patient are very supportive. Others reported feeling supported through individual practices of meditation and reflection and attending workshops and reading about the phenomenon.

According to Burnard (1989) nurses should acknowledge the existence of intuition and be open to the idea of experiencing intuitive thoughts and feelings. By nurses trusting their judgment and allowing themselves to take risks in talking about their intuition with others, they find that their intuitions are right and they can respect their intuitive abilities even more.

In contrast to the supports felt by nurses, barriers to the use of intuitive judgments have also been identified. Nurses are sometimes reluctant to trust their intuitive experiences because they have been educated to obtain only objective data and to provide a scientific rationale for all of their judgments and behaviors (Benner & Tanner, 1987). A recurrent theme was devaluation of intuitive judgement by other nurses (Benner & Tanner, 1987, Pyles & Stern, 1983; Rew, 1991a, 1991b; Schraeder & Fischer, 1987). This might include comments, looks, or a feeling of ridicule. Schraeder and Fischer (1987) identified the frustration experienced by nurses in their efforts to communicate intuitive experiences to others. Judgments of experienced nurses based on intuition were generally respected and expected but were also clouded with ambivalence.

Nurses who acted on their sense of intuition found that in environments that value logic, hard data, and professional detachment, the use of intuition resulted in being labeled frequently as "overinvolved" and "overly emotional." Nurses felt indignant and frustrated, and the negative labeling of their nursing judgments created periods of self-doubt and stress (Pyles & Sterns, 1983). Many intuitive nurses were often reluctant to talk about their use of intuitive knowledge because of the lack of support they experienced (Benner & Tanner

1987; Pyles & Stern 1983; Rew 1986, 1988a, 1988b, 1990, 1991a, 1991b; Schraeder & Fischer, 1987).

A barrier given by nurses in Rew's study (1991) was their job description and the boundaries of role as a clinical nurse. When these nurses found themselves in patient situations in which they could not intervene without physician support, i.e. the ability to prescribe medications, they felt they could not control outcomes. Feelings of self-doubt and fear from having had bad outcomes were mentioned by nurses as barriers. Extreme work overload and staff shortages, including inexperienced nurses and a high staff turnover, were given by Benner and Wrubel (1982) as things nurses felt would stifle their use of intuition.

Summary

The concept of intuition is gaining acceptance as a valid and trustworthy way of thinking and knowing. Gerrity (1987) talks about the need for nurses to recognize the value in having people in nursing who use an intuitive way of obtaining knowledge and processing information which differs from that of the majority of nurses. She notes that nurses need to review educational programs so that teaching methods which encourage intuitive students to develop their intuitive abilities are also included. Benner and Tanner (1987) state that intuition appears to be a legitimate and essential aspect of clinical judgment. Burnard (1989) notes that intuition is one of the basic qualities of nurses which can help nurses understand clients and fellow nurses. Miller and Rew (1989) state that conceptions of nursing processes must expand to include both analytical and intuitive ways of knowing. Both are

prerequisite to expert clinical practice. Moch (1990) states that personal knowing through introspection, integration of thoughts, and association with what is presently known, is essential to developing knowledge which is central to the practice of nursing. Rew (1991b) states that intuition in nursing practice is a complex phenomenon and more research needs to be done to its exploration. Nurses receive a linear model of nursing practice in their basic nursing education but it is being shown that expert nurses make decisions about patient care using more than simple analytic reasoning. Schraeder and Fischer (1987) believe that the art of nursing occurs on an intuitive level and nursing researchers must study this phenomenon. If we are to understand how nursing is actually practiced, nurses must describe and document how this method of thinking evolves and what influence it has or how it is influenced by the present environment.

The actions of nurses who pressure their peers and physicians until someone listens to intuitive judgements suggests characteristics of risk taking, strength of conviction, and an ability to think and to act on knowledge based on alternatives to the biomedical model. These actions have profound implications for nursing practice. Clearly, as Young (1987) has stressed, intuition should not be ignored.

To date, the study of intuition in nursing has hardly been exhaustive. There is increasing evidence that nurses, depending upon their level of experience, use intuition in their clinical practice to make decisions about patient care (Benner and Tanner, 1987; Gerrity, 1987; Pyles and Stern, 1983; Rew, 1988, 1991; Schraeder and Fischer, 1987; Young, 1987). These

researchers also state that nurses are sometimes reluctant to trust their intuitive experiences because they have been educated to obtain only objective data and to provide a scientific rationale for all of their judgments and behaviors. Nurses often use intuition but frequently they will deny its use if questioned.

At present, most studies have been done with nurses in the critical care field. All practice settings require skillful clinical judgment but it is especially important in maternal-child health care (Schraeder and Fischer, 1986) as rapid change is normal and patients are very dependent on their caregivers. Therefore, this study of the use of intuition by obstetrical nurses is indicated.

CHAPTER THREE

METHODOLOGY

Research Design

This methodology review regarding the use of intuition in clinical practice will provide the research design, the protection of the human subjects and the sample and the sampling plan. A discussion of the data collection tools and procedures and the pilot study will be included.

This descriptive exploratory study described the phenomenon of intuition as used by nurses caring for laboring clients and reported to the researcher in personal interviews. Nursing scientists (Brockopp & Hastings-Tolsma, 1995) have suggested the use of a variety of research approaches and have noted the contribution of qualitative methodologies to a discipline that is building a knowledge base. Nursing has historically been concerned with the wholeness of human beings and since qualitative research is based on assumptions consistent with a belief in human wholeness, it is of value in the generation of knowledge unique to nursing (Brockopp & Hastings-Tolsma, 1995; Burns & Grove, 1993; Polit & Hungler, 1991, 1993; Streubert & Carpenter, 1995). Qualitative methods seem particularly useful for developing facts and concepts about the use of intuition by intrapartal nurses.

The reliability and validity of qualitative research is found in the trustworthiness of the study. Trustworthiness is defined as accurately representing the experiences of the study participants (Streubert & Carpenter, 1995). Lincoln and Guba (1985) refer to concerns regarding scientific rigor in qualitative research as issues of trustworthiness and suggest trustworthiness

may be established by using measures of dependability and confirmability. Confirmability is a process criterion which can be documented by an audit trail (Streubert & Carpenter, 1995). An audit trail is the systematic collection of material and documentation that allows an independent auditor to come to similar conclusions about the collected data (Lincoln & Guba, 1985). Dependability is the stability of data over time and conditions (Polit & Hungler, 1993).

The information obtained by the investigator during personal, audio-taped interviews came from responses to questions in the interview schedule. The interview schedule, containing four questions designed to elicit information about the use of intuition by intrapartal nurses, was similar in content and format to the interview schedule used in previous studies of intuition in nursing (Rew 1988, 1990, 1991), thus providing support for its confirmability. The researcher established an audit trail (Lincoln & Guba, 1985). The demographic data were tabulated and reported in narrative form. Dependability was addressed by determining agreement about coding among the researcher and two associates who are obstetrical nurses with Masters in Nursing preparation. The audit trail itself demonstrated confirmability.

Protection of Human Subjects

Permission was obtained from Drake University Human Subjects Committee to proceed with this study. Permission was then obtained from the appropriate department heads of the three participating hospitals in the metropolitan area before the interviewer proceeded with this study.

The human rights of the subjects were safe-guarded. Each subject was told the purpose and nature of the study, how they were selected and how the obtained results will be used. The subjects were informed that they could refuse to participate and could withdraw from the study at any time. The reader is referred to a copy of the consent form in Appendix A. All subjects have requested and will receive a copy of the results of this study. Subjects were assured of confidentiality through the use of code numbers assigned at the time of the interview. Data were reported as group data. The recorded tapes and transcriptions are kept locked in the investigator's office.

Sample and Sampling Plan

The investigator recruited the participation of intrapartal nurses through nurse managers of the obstetrical areas of the three participating institutions. Fifteen intrapartal nurses agreed to participate. The director of nurses, vice-president of maternal-child services, and/or nurse manager at each of the three institutions was contacted by telephone and an explanation of the study was given and permission was obtained to interview intrapartal nurses at each institution. A copy of the study proposal was given to each department head for review. Letters of introduction and request for participation were distributed to each intrapartal nurse via personal mailboxes at their institution by the respective nurse manager (Appendix B). A sign-up sheet requesting names and telephone numbers of participants was placed on the unit and was collected by the researcher on the designated date (Appendix C). Volunteers were then contacted by the researcher to confirm their willingness to participate in the study and to make appointments for personal interviews.

Description of Data Collection Tools

Two data-gathering instruments were used: A Demographic Data Questionnaire which includes the visual analog scale and an Interview Schedule. Each will be described. The Demographic Data Questionnaire (Appendix D) was designed by the researcher and includes questions about: age; gender; marital status; child-bearing history; educational preparation; years of clinical obstetrical experience. A visual analog scale ranging from 0 to 10 with 10 being very intuitive, 5 being moderately intuitive, and 0 being not intuitive at all was included with the Demographic Data Questionnaire. Each subject was given a questionnaire to complete prior to the interview. The Interview Schedule (Appendix E), a modification of the interview schedule designed by Rew (1988), contained four questions designed to elicit information about the use of intuition by intrapartal nurses.

Description of Data Collection Procedures

The protocol determined by the three participating institutions was followed for the recruitment and inclusion of intrapartal nurses in the study. A sample of intrapartal nurses was recruited from the three local hospitals which agreed to participate in the study and allowed the investigator access to these nurses. All intrapartal nurses within the three institutions were given letters of introduction and were asked to participate in the study. A sign-up sheet was provided for each unit and was collected by the investigator on the appropriate date. The nurses who volunteered to participate were personally contacted by the investigator and appointments were made for personal interviews. The interview was conducted by the investigator and each interview was tape-

recorded. The interviews were conducted in a quiet room in the subject's individual clinical area.

Before each interview, the investigator again explained the purpose and procedures of the study to the participant. Each subject was asked to sign a letter of consent approved by the university research committee and the healthcare institution committee responsible for the protection of human subjects. Each subject was then asked to complete the demographic data questionnaire which included the self-rating score in intuitive ability using a visual analog scale. The investigator then conducted the tape-recorded interview following the interview schedule and kept brief field notes. Each interview lasted an average of 25 minutes. The range of length for all interviews was 15 to 50 minutes.

After the interview, each subject was shown the interview guide with the investigator's field notes and was invited to clarify any response that was unclear or incomplete. Each subject was asked if they wished to change their self-rating score of their own intuitive ability and was given the opportunity to do so. Information was transcribed and reported in narrative form. The participants self-rating score of intuitive ability on a visual analog scale was reported both as an individual score and an average score.

Tape recordings were transcribed verbatim by the investigator. Transcripts were typed in columns containing an average of 10 words per line. A parallel column of space was available for reducing data to categories and phrases. The reader is referred to Appendix F for a typical example. The interview schedule and tape recording of the interview were analyzed for both

manifest and latent content. Transcriptions were analyzed for both manifest and latent content in the following manner: First, each transcript was read by the investigator while listening to the tape-recorded interview. Notes were made on the transcript to indicate emphasis or voice inflections on certain words or phrases. Second, each transcript was compared with the investigator's field notes taken at the time of the interview. Any additional comments from the field notes were added. Third, the responses provided by each subject to each question were separated out into the question categories - definitions, clinical examples, supports and barriers. Fourth, each category was examined for themes embedded within it.

Pilot Study

A pilot study using the demographic data questionnaire and interview schedule developed by the investigator was conducted to determine the clarity of the data-gathering instruments and the agreements of experienced intrapartal nurses. Personal audio-taped interviews were conducted with two intrapartal nurses following the described data collection procedures.

Samples of two transcribed interviews were coded by the investigator to distinguish data belonging to the predetermined categories and for data belonging to themes within the categories. Copies of the transcribed pilot study samples were provided to two associates for their review and coding of information into the predetermined categories and for data belonging to themes within the categories. The reliability between the investigator and the interrators was one-hundred percent.

Age in years	23	24	28	29	35	38	39	41	42	52	53	62
Number at age	2	1	1	1	1	1	3	1	1	1	1	1
Average age of participant 37.8 years												

The fifteen participants had intrapartal clinical experience ranging from two to forty years with an average of 11.86 years. (Refer to Table 2). Three participants had additional post-partum experience averaging 4.33 years. Two participants had additional newborn nursery experience averaging 6.5 years.

Table 2. Intrapartal Clinical Nursing Experience of Participants

Years Labor/Delivery Experience	2	3	4	5	7	10	13	14	15	17	18	20	40
Number of Participants	1	2	1	1	2	1	1	1	1	1	1	1	1
Average Number of Years per Participant	11.86												

The results of the visual analog scale indicated that all participants considered themselves to be moderately to highly intuitive. All scores ranged from five to nine with an average score of 7.06. The average score was 7.00 before one participant changed her self-scoring from six to seven after completing the interview. The scale from 1 to 4 has been eliminated in Table 3 as there are no participant scores to be reported. (Refer to Table 3).

Table 3. Participant Self-Ranking of Intuitive Ability on Visual Analog Scale

Scale	5	6	7	8	9	10
	Moderately					Highly
	Intuitive					Intuitive
Frequency	3	2*	3*	5	2	0
of response						
* One participant changed self-ranking from 6 to 7 after interview.						

It was thought that among women with children the visual analog score might be higher than those who had not had children. When comparing child-bearing experience of the subjects with the results of the visual analog scale, it was found that the two subjects who had not been pregnant gave themselves scores of 6 and 8. It may be useful to investigate this further in the future.

Interview Schedule Analysis

The interview schedule used by the investigator contained four questions . The responses provided by each subject to each question were separated into the appropriate categories of definitions, clinical examples, supports and barriers. This was necessary as responses frequently contained references to categories other than the specific question being asked. Each category was examined for themes embedded within it.

The first question concerned how intrapartal nurses defined intuition in clinical practice. Definitions for intuition given by the participants in this study ranged from specific, short answers to elaborate, long answers. The majority of the responses talked of "gut feelings" and "feelings of knowing." Some talked of having a "sixth sense" explained as "knowing that something is going to happen" and/or "feeling that something is different." One participant stated that intuition is a "combination of observation skills that you have picked up over the years of experience, along with your education."

Intuition was defined as a "gut feeling", "gut reaction", "just my gut" more often than any other definition. "Having a feeling, kind of gut feeling, from experience that something might or might not happen" was often voiced. "Knowing" or "sensing" was also included with "gut feelings." "Sensing of either well-being or problems" and "over all feeling and sensation of comfort or discomfort" were given. "Sensing things about patients before you see clinical indicators" or "getting a sense of knowing how things progress in labor but not having that physical information to back you up" was often mentioned.

To others, intuition was an "ability that is just there." Another felt that it was an "inner ability to foresee any changes at the approximate time of delivery or other changes in the prognosis of the patient without any laboratory results, ultrasounds, or other things." It was the "ability to automatically act on your feelings and knowledge" and the "ability to make split decisions without having to ask someone else for an answer."

Participants were very straight forward in their definitions and all included "sensing", "knowing" and/or "feeling" in some degree. When giving definitions, no subject hesitated. Some were very animated and excited while others were very matter-of-fact. All were very self-assured and confident. It was evident that the participants had all had experiences of using intuition in their clinical practice and that they were very comfortable with its occurrence. The subjects' responses were coded for themes including definitions, feelings and thoughts. Emerging themes were "feelings" and a type of "knowing." The results of this analysis of definitions of intuition appears in Table 4 which follows.

Table 4. Frequency of Themes in Intrapartal Nurses' Definitions of Intuition

Theme	Number of Subjects	Frequency of Phrases
Gut feelings	15	77
Feelings of knowing	15	67
Sensing something will happen	13	50
Ability that is just there	10	22
Sixth sense	5	6
Hunch	3	4

The second question concerned descriptions of examples of using intuition from their own clinical practice. When discussing the types of clinical situations the participants described as examples of using intuition in their clinical practice, all listed situations that occurred while giving nursing care to the laboring client. One nurse stressed that this included "assessment, observation, patient emotional and psychological support, and physical support including pain medication."

When participants described experiences that they had had with intuition, one nurse stated that "intuition starts when you first meet the patient and do the admission history and included everything in labor and delivery."

One nurse mentioned that during a "precipitous delivery there is no physician at all and I just kind of intuitively take care of things."

Nurses described experiences with fetal monitoring - "sometimes you have a monitor strip that looks just perfectly fine and yet within yourself you know that there is a problem." Another nurse described a situation when after two to three minutes the fetal monitor strip was non-reactive and she contacted the physician who proceeded with cesarean delivery which resulted in an infant who was compromised but alive. A nurse mentioned caring for a patient who had come for an Oxytocin Challenge Test (OCT). The test was negative as no late decelerations were found on the monitor tracing. However the nurse stressed that "there were no accelerations in the strip either for quite a long period of time. We (nurses) did not feel right about sending her home." The nurse spoke to the doctor to say that they were concerned - that the baby was not doing well, that it wasn't having any decelerations but there weren't any accelerations which made the nurses uncomfortable. The physician stressed that clinically speaking by the textbook it was all right for the patient to go home with a negative OCT and that is what we should do with this patient. The nurse stressed that "the patient came back with a stillborn." Another nurse talked of her experiences when she worked for a homecare fetal monitoring company and she mentioned that "it was kind of intuition over the phone. It was kind of hard because you couldn't see the patient, but you really had to listen to what they were saying and your gut feeling kind of guided the way."

Other nurses mentioned that it is the action of the mother/patient - "she seemed more distressed than what she should be as far as pain and

discomfort." "It is just a sensation when you get in with a patient that just comes over you.... I don't know what it is unless it is intuition." Several nurses stressed that "you're just kind of paying attention to the subtle signs." One nurse mentioned caring for a patient the physician thought had "flu-like symptoms but it just didn't feel like flu and it developed into pre-eclampsia."

A nurse talked of caring for a pre-term labor patient with twins who had been on labor suppressing drugs and had been stable for three days. The patient was complaining of abdominal bloating and another nurse had suggested that the patient be placed on a bedpan. This nurse did not "feel right about sitting her on the bedpan" and she notified the physician who stated that she had ordered a stool softener for the patient and that was probably the cause of the discomfort the patient was feeling. "I just didn't, again, I just didn't feel right about sitting her on the bedpan and I called the physician in. She was angry and she did proceed to check her (sterile vaginal exam) and she was complete(ly dilated) and they did an emergency cesarean section in about fifteen minutes and delivered premature twins."

Several nurses mentioned experiences during the patient's delivery. One nurse described the situation as follows: "It was like there has been a spark at delivery, like a prolapsed cord. You know it was like I just knew that this was going to happen. Just the lady's symptoms - big bag of water, baby was so high, and it was crazy, but it was just like I feared this on this lady and by golly it happened. Thank goodness for that gut!"

The majority of the participants felt that their intuition occurred while they were at the patient's bedside. One nurse stated that intuition occurred in

"seventy-five percent of what I do." Another nurse stated that her intuition occurred when she was working by herself on something but "I guess it could happen anywhere."

A broad range of emotional feelings were described in association with experiences with intuition. The responses could be categorized into good outcomes and bad outcomes. Those responses falling into good outcomes are: "excited", "happy", "good - my gut feeling usually is pretty accurate", "uplifting." Those responses falling into bad outcomes are: "uneasiness", "sense of knowing something is wrong", and "fear." One participant summed it up with the statement, "If it is associated with a bad situation, if I have the feeling of a bad outcome, I get a feeling of uneasiness. I get an uplifting feeling if I feel good about something, if I feel it will be a good outcome, it is uplifting."

One nurse described her intuition as a feeling "not like you are in control but kind of." A few nurses mentioned feeling anxious and having a sense of nervousness. The majority expressed feelings of "self-confidence" and "increased self-esteem." One nurse expressed an "urgency to act, a calling." Another nurse described it as "self-doubt versus self-confidence." "Feeling satisfied with my ability to pick up clues and the ability to put things together" was expressed by another nurse. Being excited, especially if their intuition was right was expressed by others. Only three participants stated they had little or no emotional sensations associated with intuitive experiences.

Physical sensations associated with experiences of intuition again fell into two categories - good outcomes and bad outcomes. Those nurses

mentioning bad outcomes made comments like, "I get a bad feeling, a slam in the gut that something bad is happening" or "it is not necessarily a pleasant sensation and sometimes it is doom." The majority of nurses mentioned the good outcomes and made comments like, "my heart starts racing sometimes when things are going." Other physical sensations mentioned are "nervousness", "an adrenalin rush", "queasiness", "headaches", "increase in blood pressure" and "nausea." One nurse replied, "nausea, palpitations, you know I think you react as you do in any situation, sometimes you get sweaty and nervousness."

One nurse stated that "again if it is a poor situation, I feel nauseated, sometimes I get a dull headache; if it is good, if it is a good outcome I usually have butterflies in my stomach and I get jittery." One nurse simply stated "the gut feeling." Another talked of "just being physically tired." All participants voiced having physical sensations of varying types and intensities.

When discussing thoughts that the participants associated with experiences of intuition, the responses ranged from simply "was it right or wrong - usually my intuition is right" to "patient centered - keeping their interest foremost in mind" to "past experiences." Thoughts were almost always positive and expressive of "pleasure in being right" and of "doing a good job." One response was simply "accuracy." One statement said "the thoughts always go back to the patient. I have to say or do what I think is best for the patient. I have to keep their interests foremost in mind. I have to get all of this information that I think I have physically seen and physically felt to the doctor."

The majority of nurses responded that they were doing patient care at the bedside just prior to an intuitive experience. Some specifically stated that they were doing assessments. Some nurses were just "being aware" or "sitting quietly charting."

Activities immediately after an intuitive experience were usually connected with action - "caring for the patient", "talking with other nurses and co-workers", "analyzing the situation", and "making appropriate decisions." One nurse stated that "sometimes I have sat and cried - if it was a good outcome, the tears are happy, if it was a bad outcome, you cry because you are sad." Some participants stated that they "feel real hyper and need a release and probably can't sleep."

The emerging theme found most frequently was "labor", defined as uterine contractions causing the cervical dilatation, effacement or both. All aspects of the labor process including both normal and complicated were given. The subquestions were also analyzed. "Patient care", "observation" and "patient fear" were the emerging themes for the first subquestion dealing with experiences in intuition. Intuition occurred primarily at the "bedside" while doing "patient assessment." Emotional feelings and physical sensations fell into two categories - those dealing with "good" outcomes and those dealing with "bad" outcomes. "Past experience" was the thought theme most often found. "Patient care" was the theme of answers dealing with just prior to intuitive experiences, while "talking" and "analyzing" were the themes just after an intuitive experience. Table 5 presents the frequency of the use of intuition in clinical practice.

Table 5. Frequency of Themes in Intrapartal Nurses' Use of Intuition in Clinical Practice

Themes	Number of Subjects	Frequency of Phrases
Labor and delivery	15	55
Patient care at the bedside	15	51
Patient assessment	14	34
Fetal monitoring	12	42
Preterm labor	7	8

The third question dealt with supports for acting on intuition. When participants were asked what they considered to be supports for acting on their intuition, the primary answer was other nurses - "when we sat around and talked to somebody and heard of their experiences, to me these are teaching situations of hearing what other people have gone through, have seen, have done." Fellow nurses "understand the situations and accept your intuition and are supportive of it." "It is the nurses I work with, you know that they will always listen to you." Some nurses say that it depends on the experience their co-workers have had, but it is just talking to someone else and "knowing that they care and understand."

Several nurses listed physicians as being supportive, but their answers were always qualified by stating "physicians that trust you." It was stressed that

if the "physician respects your knowledge and ability and is supportive of my following my intuition" he/she will respond to nurse's requests without questioning. One nurse stated that "physicians do not have the intuitive skills that nurses have."

Experience was also listed as being a support. "My outcomes from previous intuitions that are usually proven right." "Being aware; continuing to learn, and being a people person in that you are aware of what is going on with them emotionally, facial expressions, and the whole bit." One nurse stated that experience was very necessary "as a lot of things you don't learn in your basic nursing education. You learn by doing, the more you do, the technical type of skills you know, all help with your knowledge base."

Patients are also supportive. It can be in "patient verbalization or in their non-verbal body language". Several nurses mentioned patient recognition and support of their intuitive skills and they felt that this was incentive for continuing the use of intuition in their clinical practice. The most common theme for support to the use of intuition was "fellow nurses", those who have had similar experiences of their own. Other themes were physicians, past experiences and patients and their families. The results of this analysis of supports for using intuition appear in Table 6 which follows.

Table 6. Frequency of Themes in Intrapartal Nurses' Description of
Supports For Using Intuition in Clinical Practice

Theme	Number of Subjects	Frequency of Phrases
Fellow nurses	14	37
Past experience	13	33
Good outcome	10	25
Self-confidence	6	14
Patients	6	10
Physician's trust	6	6

The fourth question dealt with barriers to the use of intuition.

Physicians were identified by participants as the primary barrier to the use of intuition in clinical practice. "Occasionally they tend to scoff at the thought that this could happen." "Doctors don't have intuition that nurses do." "Residents tend to listen to nurses a little more than other physicians would because of our experiences." One nurse stated that physicians, especially those that have not been in practice very long, are more statistically minded and are "not as willing to listen to nurses when we tell them that there is something wrong even though things look all right." Another nurse responded "I think sometimes that doctors are so scientific that they don't trust the whatever." Several mentioned that the biggest barrier "is when you call the doctor and tell them what you are

feeling and they kind of blow it off." One nurse stated, "sometimes the doctors; your intuition can be strong and other nurses can agree with you and I guess you disagree with the doctor and you act on your intuition."

A few nurses felt that doctor's orders - routine orders, procedures, protocols - are barriers as "they want you doing things a certain way and your intuition might be limited by that." "Its kind of, supposedly like a check list kind of thing, you know, so if you want to be real rigid and stick to the guide then it may block some of the intuitive kinds of things that you do." Other felt that supervisory people, "director of the unit or someone you are working under" are not responsive to the use of intuition because "how do you write it down."

Another barrier mentioned was "that you can be totally wrong." It was felt that "all patients are individuals and you can't judge just because of your prior experience." "Being too confident that your sensation is accurate and the worry that maybe this time your intuition is wrong." "Having a bad experience" was given by several nurses. They said that bad experiences make you worry that you are "clinically strong and picking up on all the keys that you need to, always being alert and not afraid you will "under act."

"People not believing" was also mentioned as a barrier to using intuition. "I think that the biggest fear especially for nurses" is when "people do not believe - they turn off the light and do not pay attention to what you are saying."

The politics of healthcare was also mentioned as a barrier. "The fact that our business, labor and delivery, is a high risk malpractice area. It makes you feel like you can't miss a thing. You are responsible for everything." One

nurse mentioned that "you are always self-doubting yourself, what could I have done or what did I miss."

Technology and staffing were listed as barriers. "I think I am so concentrating on the mechanical aspects of it that my intuitive thoughts are just buried." Patient care load was also mentioned stating, "if you are taking care of several patients at one time, you can get spread so thin that you don't have a chance to really consolidate your thoughts." Others listed the lack of appropriate staff and equipment, i.e. having intensive care nursery personnel at deliveries, as barriers. "I would say that anything that interferes with you doing your job -- that you are too tired, that you are not in complete control or because I all ready have too many patients. Stress."

"There is not the research out there that proves that it is important to follow your intuition -- so there is no back-up, so to speak." "I suppose you want to stay professional, you don't want someone to think that you are some kind of kook that just goes by intuition." Some talked of going to workshops and conferences looking for explanations to help them understand their own intuitive actions and the actions of their peers but most stated that they have not been able to find them.

The predominate theme for the question dealing with barriers to the use of intuition was "physicians." Some nurses felt that not the physician but physician orders and procedures, protocols, and hospital politics upon which the physician had influence were barriers due to their scientific basis. Some nurses mentioned "people not believing", "being totally wrong", "bad experiences", and "being too confident." Technology, staffing, being a high risk

malpractice area and a lack of formal research were also given as barriers to the use of intuition in clinical practice. Table 7 presents the frequency of barriers to the use of intuition in clinical practice.

Table 7. Frequency of Themes in Intrapartal Nurses' Description of Barriers For Using Intuition in Clinical Practice

Themes	Number of Subjects	Frequency of Phrases
Physicians	12	21
Being wrong/ bad outcomes	10	15
Not being believed	6	6
Doctor's orders, protocols	5	7
Technology and staffing	3	5
Being too confident	2	4
Politics of health care	2	2
Research, lack of	1	1

Summary

The intrapartal nurses who participated in this study were very open and appeared very relaxed as they related their feelings and ideas regarding the use of intuition in their daily clinical practice. They were animated and excited when talking about their successful experiences. They were solemn and quiet

when discussing the outcomes that had not been successful. At times frustration was evident as they talked of their attempts to communicate their feelings to others, mainly physicians, trying to get them to act on the patient's behalf. One nurse stated, "You talk to the doctor and you know you have trouble and you can't get them to respond. It is a horrible feeling of knowing that you've got to say something; sometimes I say -- what do I have to say to you to get you to respond to me?"

The existence of intuition and its use by intrapartal nurses was not disputed by the participants of this study. One nurse stated that she felt that the "gut feelings" came from "knowing your craft." One nurse stated that "intuition is a tool you can use in your practice." Another nurse stated that "labor and delivery is really an intuitive field, more than any other place. It just seems that labors can go so differently that you kind of go by your gut a lot."

One participant who was very open and enthusiastic about using intuition in her daily practice talked of telling almost all of her patients sometime during her care that "my gut tells me..." She said that they would just smile about it but they did listen to what she said as after the delivery, the patient would tell the physician about it - "well you know she said we would deliver here by (whatever time was given)." She felt that this was good reinforcement for her in supporting the use of her intuition. If it was not supportive, she would not want to speak up or follow her gut. She concluded by saying, "You know, I would be intimidated by that feeling and I am not, not at all. I think that it is very important, and I would venture that with a lot of labor and delivery

nurses, they are going to agree. The more they talk the more they are going to say, 'Ya, I do function with my gut feeling.'

CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND IMPLICATIONS

Discussion of Findings

The fifteen intrapartal nurses who participated in this study all defined the attributes of intuition as identified by Rew (1986) in her conceptual analysis. Rew's conceptual attributes were "knowledge of a fact or truth", "immediate possession of knowledge", and "knowledge independent of the linear reasoning process." The participants in this study all talked of "knowing that is just there", "knowing something was going to happen", and "sensing things about patients before you see clinical indicators".

The antecedents of intuition, as delineated by Rew (1986), were identified by responses to the question "What are you usually doing just before an intuitive experience occurs?" Nurses in this study stated that experiences with intuition occurred at varying times and places, but usually the experiences were associated with being with the patient. Many nurses mentioned they were doing patient assessments at the time that they were aware of knowing that something was going to happen and they did not have solid clinical evidence to support their feelings. These responses were congruent with Rew's (1986) findings that antecedents are given as truths or knowledge that are not apparent or available through conscious reasoning, and supported her findings.

The consequences of intuition, as delineated by Rew (1986), were identified by responses to the question "What do you do immediately after an intuitive experience occurs?" In this study there were four basic behaviors into

which the nurses' activities could be grouped: (a) they all told another person, usually a co-worker, about their experience; (b) they tried to validate their findings by gathering additional information; (c) they notified the physician of the occurrence and most also included their feelings; (d) they made decisions regarding the patient and continued with giving patient care until the situation was resolved. These four basic behaviors were consistent with Rew's (1986) findings that nurses verified the fact or truth through linear analysis and applied the knowledge in both theoretical and practical ways.

Fellow nurses were unanimously stated to be the primary source of support for acting on intuition in clinical practice. They were counted on to be the ones who understood, who would not question, and would be there to help in times of need. Other sources of support were experience, patients and some physicians. Previous studies of the use of intuition by nurses in critical care, home health care, psychiatric-mental health, and holistic nurses all listed fellow nurses as the primary source of support for acting on intuition in clinical practice (Benner & Tanner, 1987; Benner & Wruebel, 1982; Bourn, 1993; Gearhart & Young, 1990; Pyles & Stern, 1983; Rew, 1986, 1988a, 1990, 1991b; Ruth-Sahad, 1993; Schraeder & Fischer, 1987; and Young, 1987).

The primary barrier for acting on intuition in clinical practice was the physician. Some respondents identified that physicians were too scientific, more statistically minded, and less intuitive than nurses. They also identified doctor's orders, procedures and protocols, all things over which the physician has control, as barriers. Feelings of others "not believing", having had "bad experiences", "being too confident" were also identified. All barriers given by

intrapartal nurses in this study had been identified in previous studies by nurses in various clinical areas (Benner & Tanner, 1987; Benner & Wrubel, 1982; Pyles & Stern, 1983; Rew 1986, 1988a, 1988b, 1990, 1991a; Schraeder & Fischer 1987).

Having identified the supports and barriers to the use of intuition it is reasonable that nursing and nursing education identify guidelines to assist clinicians and students in enhancing their intuitive processes. Davidhizar (1991) offers six guidelines for the nurse seeking to develop intuition: (a) Intuition must be respected. Unless the nurse is consciously willing to allow intuition to operate, intuitive ability will be stifled. (b) Intuition requires self-confidence. Self-respect and trust in one's own intuitive judgment is necessary to rely on feelings in decision making. The nurse must also appreciate their own intuitive potential and grant personal permission to let intuitive potential develop. (c) Intuition requires experience. Intuition is most effectively used by experienced, expert nurses. (d) Intuition involves risk. Intuitive decisions are often made with incomplete information which requires risk. (e) Intuition requires consideration for the whole. Pattern recognition is not taught but is developed by practice, self-analysis, expert feedback on performance, and ongoing integration of what is learned. (f) Intuition can be learned from a mentor. It has been shown that close affiliation with a role model who demonstrates intuitive qualities can help a nurse develop her own intuitive abilities.

The intrapartal nurses participating in this study were in agreement with Davidhizar and the guidelines for developing intuition. The nurses reported

that they had respect from their fellow nurses and they were self-confident or would not be able to follow their intuitive urges. Many of the nurses mentioned past experiences with intuition as having influence on their present day use of intuition in their clinical practice. Past experiences allowed the nurses to assess the patient situation as a whole and not concentrate on specific symptoms or actions. Intrapartal nurses acknowledge the risk taking aspects of using their intuition, especially when discussing communication with physicians. The nurses in this study did not mention mentoring as a way of learning developing intuition, but they did mention that new, inexperienced nurses did not demonstrate the intuitive qualities of the experienced nurses.

Nursing education has relied on rational data-gathering as the principal way to gain knowledge at the expense of intuition. Correnti (1992) states that intuitive knowledge is an essential component of the art of nursing and of the nursing process. She stresses that nurses often use intuition, though usually subconsciously, in their patient care and intuition is based on both knowledge and experience. The expert, intuitive nurse is holistic as opposed to fractionated or procedural.

Bevis and Watson (1989) state that nursing and education are based on human science and require theories that allow multiple realities and intuitive and constructed knowledge as well as procedural knowledge. Correnti (1992) stresses that intuitive knowledge is an essential component of holistic nursing assessment and nursing care and nurses need to become actively involved in opening nursing minds and teaching methodologies to alternative ways of teaching, learning, and knowing. Nursing judgment and assessments will be

will be intensified when we provide opportunities and experiences for learning and improving intuitive skills.

This study confirms and supports the previous findings that nurses use intuition in their clinical practice to make decisions in patient care (Benner & Tanner, 1987; Gerrity, 1987; Pyles & Stern, 1983; Rew, 1988a, 1988b, 1991b; Schraeder & Fischer, 1987; Young, 1987). The influence of past experiences and the use of this knowledge to make critical decisions regarding patient care is what Benner (1982) described as "intuitive grasp.". This study supports Correnti (1992) and her contention that we need to become actively involved in opening out minds and our teaching methodologies to alternative ways of teaching, of learning, and of knowing. She stresses that nursing judgments and assessments will be enhanced when we provide opportunities and experiences for learning and improving intuitive skills.

Implications for Advanced Nursing Practice

The identification of the use of intuition by intrapartal nurses adds to the body of knowledge regarding intuition use among nurses. Participants described clinical situations using their intuition that included assessment, observation, patient emotional and psychological support, and physical support including pain medication. This study helps to demonstrate that intrapartal nurses use more than simple analytic reasoning in making decisions about patient care. Nurses described a sensation that was suddenly there when they were with a patient. Nurses reported that intuition starts when you first meet the patient and continues from the admission assessment through the delivery. It supports Benner's (1987) contention that intuitive knowledge and analytic

reasoning do work together. Experiences have been described by nurses in this study as situations that appeared normal and yet within themselves they knew that there is a problem. The results of this study will help make intuitive judgment an acceptable aspect of nursing practice. The profession's willingness to accept the use of intuition in clinical practice will result in more expert clinicians and an enhancement of patient care.

Recommendations for Further Study

Intuition is an evolving and influential mode of thinking in the practice of nursing and should not be ignored. The actions of nurses who pressure peers and physicians to listen to intuitive judgement shows strength of conviction and an ability to think and to act on knowledge based on alternatives to the linear, analytical model. These actions have profound implications for nursing practice. Research into the use of intuition by nurses in their clinical practice is still in its infancy. While earlier studies have identified the use of intuition in critical care, home health care, holistic nursing, psychiatric-mental health, and neonatal intensive care (Benner & Tanner, 1987; Pyles & Stern, 1983; Rew, 1988, 1990, 1991b, Ruth-Sahd, 1993; Schraeder & Fischer, 1987; Young, 1987), no other study involving intrapartal nurses exists.

Davidhizar (1991) offers guidelines for the development of intuition by nurses. She states that intuition must be respected. Intuition can be learned from a mentor and close affiliation with a role model who demonstrates intuitive qualities can help another nurse develop her own intuitive abilities. Further research should be done to validate the daily use of intuition by nurses in clinical practice.

Qualitative research in nursing is a relatively new accepted form of expanding nursing knowledge (Streubert & Carpenter, 1995) and seems useful for developing facts and concepts about the use of intuition by nurses in clinical practice. As the areas of critical care, psychiatric-mental health, home health care, holistic, and intrapartal nursing have been studied, it seems appropriate that pediatrics and geriatrics also be studied. Further research in all areas would help to develop an understanding of the use of intuition by clinical nurses. An instrument should be developed which would empirically measure intuitive ability in clinical nurses. Nursing researchers need to direct their attention to studying the use of intuition in the daily clinical practice of all nurses, so its use will become a respected and recognized process of providing nursing care.

Limitations of Study

This study was done with a small sample of fifteen nurses. The sample was recruited by the investigator. The nurses were from three metropolitan institutions in a urban setting which have similar nursing staffs but dissimilar patient populations. The three types of patient population are: (a) patients from lower socio-economic backgrounds; (b) patients who primarily use family practioners for their health care; and (c) patients who primarily use specialists, i.e. obstetricians, for their health care. This is the only known study which involves intrapartal nurses and their use of intuition in their clinical practice.

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APPENDICES

APPENDIX A

CONSENT FORM

You are invited to participate in a study of experiences of intuition in registered nurses in intrapartal clinical practice. Your participation in the study is completely voluntary.

The purpose of this study is to identify and describe the use of intuition by nurses caring for laboring clients and the supports and barriers to its use. Further data concerning age, sex, and educational background of the nurses will be described in approximately 20 registered nurses in the Des Moines area.

If you decide to participate in the study, Patricia Cannon, RNC, master's in nursing student at Drake University, will contact you for an appointment for an interview. The interview will be audio-taped and you will be asked a few questions about personal nursing experiences in which you felt intuition use occurred. The interview will take between 20 and 60 minutes. You will also be asked to complete a short questionnaire which will take 5 minutes or less.

Any information obtained in connection with this study will be held in strictest confidence and will be reported only as group data. Assignment of numbers will be used by the researcher. The list of code numbers will be kept locked in the investigator's office.

The benefit of participation in this study is contributing to our understanding of this phenomenon in clinical practice and helping nurses clarify how they make decisions in their practice.

Your decision whether or not to participate in the study will in no way affect your relationship with Drake University. If you decide to participate, you are free to discontinue that participation at any time without prejudice.

If you have any questions, please ask. If you think of other questions later, you may call Ms. Cannon at 241-6440 or 289-1505. You may also contact Marion Hemstrom, D.N.S., at Drake University at 271-2830.

If you would like a copy of the result of the study, please indicate so here and a copy of the results will be mailed to you. ☐ Yes, I would like a copy; ☐ No, I would not like a copy.

Thank you,

Patricia Cannon, RNC,
Principal Investigator

Date:

Your signature below indicates that you have read the above information and have decided to participate in this study. You may withdraw at any time after signing this form if you so desire.

Signature

Date

APPENDIX B

PATRICIA L. CANNON, R.N.C., B.S.
6755 N.W. Timberline Drive
Des Moines, Iowa 50313
H: (515) 289-1505
W: (515) 241-6440

May 22, 1994

Dear Obstetrical Nurse:

I am a graduate student at Drake University working toward a Masters of Science in Nursing degree. I am writing to request your participation in the research phase of my thesis, "THE USE OF INTUITION BY INTRAPARTAL NURSES".

The purpose of this study is to identify and describe the use of intuition by intrapartal nurses who care for laboring clients. The nurses perceptions of supports and barriers to the use of intuition in the intrapartal setting will also be explored.

The benefit of participation in this study is contributing to our understanding of this phenomenon in clinical practice and helping nurses clarify how they make decision in their practice.

As a participant, you will be asked to do the following:

1. Consent to a personal, tape-recorded interview with the investigator at a date, time, and place mutually acceptable to both. The interview will take between 20 and 60 minutes.
2. Before the interview, the investigator will again explain the purpose and procedures of the study. You will be asked to sign a consent form stating your willingness to participate and have the interview tape recorded.
3. Complete a demographic form concerning age, sex, and educational background, including a self-rating score of intuitive ability using the Likert scale.
4. During the tape recorded interview, the investigator will follow an interview schedule and keep brief field notes.
5. After the interview, you will be shown the interview guide with the researcher's field notes and be asked to clarify any response that was unclear or incomplete. You will also be asked if you wish to change your self-rating score of intuitive ability.

Any information obtained in connection with this study will be held in strictest confidence and will be reported only as group data. If you decide to participate, you are free to discontinue that participation at any time without prejudice.

If you wish to participate, please sign-up on the appropriate sheet giving your name and telephone number. I will be contacting participants for interviews after Wednesday, June 1, 1994. If you have any questions, please contact me at (w) 241-6440 or (h) 289-1505.

Thank you for your consideration. I look forward to talking with you in the future.

Respectfully,

Patricia L. Cannon, RNC, BS
Graduate Student, Drake University

APPENDIX C

PATRICIA L. CANNON, R.N.C., B.S.
6755 N.W. Timberline Drive
Des Moines, Iowa 50313
H: (515) 289-1505
W: (515) 241-6440

PARTICIPANT LIST

IF YOU ARE WILLING TO PARTICIPATE IN THE RESEARCH PHASE OF MY THESIS, "THE USE OF INTUITION BY INTRAPARTAL NURSES", PLEASE SIGN YOUR NAME AND TELEPHONE NUMBER IN THE SPACE PROVIDED.
(This list will be removed June 1.)

NAME	TELEPHONE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

APPENDIX D

DEMOGRAPHIC DATA

1. Age _____
2. Gender _____ Male _____ Female
3. Marital Status: _____ Married _____ Divorced
 _____ Single _____ Widow(er)ed
4. Child-bearing History _____ Number of Pregnancies
 _____ Number of Deliveries
5. Educational preparation: check all which apply to you:
 _____ Associate degree, nursing.
 _____ Diploma, nursing.
 _____ Baccalaureate degree, nursing.
 _____ Baccalaureate degree, other; please specify _____
 _____ Master's degree, nursing.
 _____ Master's degree, other; please specify _____
 _____ Doctoral degree, nursing.
 _____ Doctoral degree, other; please specify _____
6. Years of clinical obstetrical experience:
 _____ Labor and Delivery
 _____ Post-partum _____ Newborn nursery
7. How intuitive do you consider yourself to be? _____
 (write in the number corresponding to the following scale:
 0 1 2 3 4 5 6 7 8 9 10
 not moderately very
 intuitive intuitive intuitive

APPENDIX E**INTERVIEW SCHEDULE**

1. How do you define intuition in clinical practice?
2. What type of clinical situations do you describe as examples of using intuition in clinical practice?
 - a. Would you describe your experience(s) with intuition to me?
 - b. Under what conditions (time, setting, situation) in the clinical practice of nursing has your intuition occurred?
 - c. What emotional feelings do you associate with experiences of intuition?
 - d. What physical sensations do you associate with experiences of intuition?
 - e. What thoughts do you associate with experiences of intuition?
 - f. What are you usually doing just before an intuitive experience occurs?
 - g. What do you do immediately after an intuitive experience occurs?
3. What do you identify as supports for acting on your intuition in clinical practice?
4. What do you identify as barriers to acting on your intuition in clinical practice?

APPENDIX F

INTERVIEW TRANSCRIPTION

<u>INTERVIEW</u>	<u>CATEGORY</u>	<u>THEMES</u>
Int: How do you define intuition?		
Sub: Um, the ability to....to feel something from somebody else or know something that you don't have specific facts about.	Definition	to feel) without to know) facts
Int: Ok, have you experienced intuition in your clinical practice?		
Sub: I don't think so much intuition about clinical, medical things but more just feelings about people in general, uh, knowing what type of person I'm dealing with, without really having many facts about it. But not so much about knowing medical things or knowing physical things. Does that make sense?	Feelings	knowing without facts
Int: Uh, hm.		
Sub: It's hard to describe.	Definition	"hard to describe"